UNITED STATES DISTRICT COURT

WESTERN DISTRICT OF MISSOURI

CENTRAL DIVISION

SPENCER NORMAN, KIEFER NORMAN, COURTNEY NORMAN, HELEN S. NORMAN, Plaintiffs, vs. CAMDEN COUNTY, ET AL. Defendants.	Case No. 2:12-CV-04210

VIDEOTAPED DEPOSITION OF JOHN G. PETERS, JR., Ph.D.

Taken at All-American Court Reporters
1160 North Town Center Drive, Suite 300
Las Vegas, Nevada

Taken on Thursday, August 29, 2013
At 8:59 a.m.

Reported By: Gale Salerno, RMR, CCR No. 542

EXHIBIT
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might be emotionally disturbed, and then ultimately we have an arrest-related death, right?
A. Yes. I would agree with that.
Q. And is that the type of scenario that you teach and train about?
A. Yes.
Q. And in some of your articles, I think you refer to this topic as restraint-related sudden deaths. Is that the same thing?
A. It can be the same thing. There's a multitude of labels that get put on these things by medical examiners.
Q. Right. And I'm just trying to find a way to talk about some of these things and make sure I'm not mixing up definitions. So that's another term you're okay with using?
A. Yeah, that's fine.
Q. We talked about this a little before, but how long have you been teaching and writing about this topic of restraint-related sudden deaths?
A. 1996 is when I started really teaching it. Actually first writing about it would have been 1988.
Q. How long have these issues been around?
A. Well, sudden death has been around since 1460 BC. That's the first written record we have of

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sudden death.
Arrest-related deaths is a relatively new phenomenon, probably surfacing in the 70s.
Restraint-associated death goes back into the old, what was labeled insane asylums up through today's modern hospitals.
So most of your restraint-associated type death, the literature is in the hospital arena or the mental institution category.
Q. And I think I saw in one of your articles, it said there's been research on this topic since like 1836 as far as restraint-related sudden deaths. Is that accurate?
A. Restraint-related, to some degree, 1849 is probably the first article that appeared in The American Journal of Insanity Magazine, which isn't politically correct today, but that's what it was called, The Journal of Insanity.
And it was about a dozen people who died over a period of years in McLean, Massachusetts. Dr. Luther Bell was the doctor of that institution.
So we do have some delirium-associated deaths. Some of those people were restrained.
And we also have Dewhurst wrote a book in 1981 called Willis' Case Study. And Willis was a

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doctor in the United Kingdom, and he reported a woman in, I think it's Eton, England, who died after being bound with chains and ropes in the 1600s.
So this phenomenon is certainly not new. So it's been around for a long time.
Q. Do you agree that police officers are likely to encounter emotionally disturbed persons?
A. I think in today's world, that's a reasonable expectation.
Q. It's certainly not unusual, is it?
A. Not today.
Q. Do you agree that it's a usual and recurring situation that police officers have to deal with?
A. I think in the overall global sense, that would be correct. When we look at it -- well, let me put it this way: Statistics apply to groups, not necessarily individuals.
So we may have some agencies, we may have some officers who haven't experienced much of it because of where they work or the shift they work.
But I think in the global sense, that's correct.
Q. Do you agree that supervisory training is a key ingredient to organizational effectiveness?

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A. I think that's true, yes.
Q. Do you agree that having contemporary policies and procedures is a key ingredient to organizational effectiveness?
A. Yes.
Q. Do you agree that training is one of the most important responsibilities and duties of a law enforcement agency?
A. Yes.
Q. Do you agree that well-trained officers are generally better prepared to act decisively and correctly in a broad spectrum of situations?
A. As a general rule, that's correct.
Q. Why is training important for police officers?
A. Well, I think it's important for anybody to be trained in what they're going to most likely encounter on the job.
I think the state establishes what officers need to be trained in. And when they go to the academy, they get trained in the areas that the state decides should focus on training.
And then I think if there's individual issues at the community level, then that would be something the department would do.

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certainly a medical emergency. That's what we're talking about here.
Q. So if you see some of these behavioral cues, though, struggling and resistance can indicate a medical emergency, right?
A. It can. Struggling and resistance can also indicate the development of a medical situation, but not always.
Q. Okay -- were you finished, I'm sorry?
A. I'm finished, yeah. I'm fine.
Q. Then if you go down, not the next paragraph, but the one after it, it says: "Another medical issue can quickly develop if too many officers are on the person's back attempting to hold him on the ground."
A. Correct.
Q. Did I read that properly?
A. Yes.
Q. And do you agree with that statement?
A. Yeah. If you have too much -- too many officers with too much full body weight on them, that can be potentially an issue, depending on the size of the person and the size of the officers.
Q. And then the next sentence says: "Here, too, the person may be struggling not to escape the

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situation, but simply to raise the chest to increase his ability to breathe."
Did I read that accurately?
A. Yes.
Q. And do you agree with that statement?
A. Yes. In some situations, that's correct.
Q. Do you agree that this is information that police officers should be trained about?
A. I think police officers should be trained about it, yes. But there's no requirement to train them about it.
Q. And next you -- it looks like you're comparing having too many officers on a person's back to being held under water while swimming.
A. Right.
Q. Did I rephrase that accurately?
A. Yes.
Q. Can you explain that comparison for us.
A. Well, the comparison is when you're under water, and you say come up to surprise your friend, and they see you coming and just hold you under there, you may be almost out of breath anyway. So you panic a little bit because you can't get out from under their grasp.
Here, the issue may be that the person is

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trying -- if there's a lot of weight on the person and the person is not very big, the person may have that same sense.
We now know since 2006, that it may be a respiratory gas exchange issue that may create that same type of panic, and not something that's just too much weight on the back. But that's the panic that was being compared.
Q. And the last sentence of that paragraph says, "This is not unlike a person who is being compressed onto the ground or floor by having too much weight on his or her back and then struggles for air."
Did I read that correctly?
A. Right.
Q. And you agree with that statement?
A. Yeah. Again, if it's too much weight, you know, full body weight on a person, and a lot of it, and you've got four officers standing on the guy's back, as they did in Canton, Ohio, a couple of years ago, that's an issue, or can be an issue.
Q. I would like to move now to Part III of that series. I think this is one of the articles you sent us.
A. Yes.

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Q. If you have that with you.
MR. HENSON: Hold on just a second, Kevin. That's one that I sent to you?
MR. CARNIE: That's correct.
MR. HENSON: Hold on just a second. I'll grab that. My paralegal has tabbed all these, and been very efficient.
THE VIDEOGRAPHER: Would it all right if I change the tape quickly now, because we have seven minutes left?
MR. CARNIE: Yeah. Let's change the tape.
THE VIDEOGRAPHER: This is the end of tape number two of the video deposition of Dr. John G. Peters, Jr.
The time is approximately 11:04 a.m. We're going off the record.
(A recess was taken from 11:04 a.m. to 11:19 a.m.)
THE VIDEOGRAPHER: This is the beginning of tape number three of the video deposition of Dr. John G. Peters, Jr. The time is approximately 11:19 p.m. -- excuse me -- 11:19 a.m. We're going back on the record.
BY MR. CARNIE:
Q. So before we took a break, we were looking

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for another one of your articles, right?
A. Yes.
Q. And do you have that article in front of you now?
A. I do.
Q. And could you tell me what that is?
A. Again, it's a resized Police and Security News Article that appeared in July/August of 2006 entitled Sudden Death, Excited Delirium, and Issues of Force, colon, Part III, Behavioral Cues and Response, Plans for Sudden and In-Custody Deaths.
Q. And I think in this article you make use of a hypothetical scenario; is that right?
A. Correct.
Q. And could you describe that hypothetical scenario for us that this article is based on?
A. Yeah, the hypothetical starts out that a woman on a Saturday evening in July sees a person, a male adult, about 30, dressed in his underwear smashing car windows with a stick in front of her home. The evening is hot and humid. The person appears to be drenched in sweat.
The woman calls 911. Says he's acting crazy. After he smashes car windows, he runs around the car, and then runs across the street. Smashes

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another car window. He doesn't try to get into the cars. Doesn't even look inside them. He just breaks them.
And the woman, in the hypothetical, says, "I think he's a karate student, because every time he breaks a car window he grunts and groans loud enough I can hear him from the house."
And then dispatch sends one patrol car in response to the description this woman gives and the address.
Q. And then what happens?
A. The officer gets there. Stops the car. Sees the man. He's sweating heavily, grunting loudly. He's talking to invisible people.
The officer starts out, Can I help you? The officer is ignored.
When the officer gets closer, he gives her the long stare, smashes other car window. She says he's under arrest. He ignores her. She pepper sprays the person. The spray has no effect on him. In fact, he gets angry, and then lifts the rear end of a small car.
She calls for backup, and hears the sirens coming. And the wild male continues to bash car windows.

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Backup officers arrive. Strike the man with an ASP baton. ASP stands for armament systems and procedures.
Baton strikes have no effect. The officers jump the person. He tosses them off like dolls.
They finally get the person to the ground. He struggles violently during handcuffing. Suddenly he gets calm and goes nonresponsive.
EMS is called, and the person dies. That's basically the hypothetical.
Q. And what's the purpose of putting that hypothetical in this article?
A. Basically, to describe the behavioral cues of this hypothetical individual, the officers' response. And then basically it sets up a situation that leads us into the describing of the behavioral cues often associated with this. And then a suggested response protocol that agencies could adopt or not adopt.
Q. So you mentioned this, but the article then goes on, and you list some behavioral cues that you indicate are indicative that a person is a high risk candidate for in-custody death; is that right?
A. Right. What we call -- there's some predisposing factors, and then there's behavior cues

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broken into physical communication and psychological.
Q. And what are those behavioral cues that you've listed in this article? And I think page 3 is where they're at.
A. Yes. Under the title Behavioral Cues.
Q. And what are those behavioral cues?
A. The ones that are listed in the article, the person demonstrates intense paranoia. The person demonstrates extreme agitation. The person demonstrates violent and/or bizarre behavior. The person is violent towards glass, shiny objects and materials, and other inanimate objects.
The person is running around wildly. The person is screaming. The person is using pressured loud incoherent speech. The person is naked or is taking off clothes. The person is psychotic in appearance. The person has rapid changes in emotions. The person is disoriented about place, time, purpose, or even him or herself.
The person has great seemingly super-human strength. The person has seemingly unlimited endurance. The person has muscle rigidity. Diminished sense of pain or is insensitive to pain.
The person is having hallucinations. The person shows aggression towards objects. The person

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violently resists during control and restraint, or after being restrained.

The person says I can't breathe during or after being subdued. The person is easily distracted and has a lack of focus.

The person has delusions of grandeur. Scattered ideas about things. Makes you feel uncomfortable. Or the person is described as having just snapped or flipped out.

Q. And this list of behavioral cues, you're not expecting all these to be present at every situation, are you?

A. No.

Q. This is just kind of a long list of things to look for?

A. Correct.

Q. And so any number of these could be present sometimes?

A. Correct.

Q. Do you agree that someone that is exhibiting a number of these behavioral cues needs emergency medical help?

A. They could need it, absolutely.

Q. And I think the way you put it in your article is that, you know, it indicates the person

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needs emergency medical help, not a fight with the officers over an arrest. Is that accurate?

A. I think --

Q. Let me take you to --

A. Yeah, take me to the page.

Q. Page 2, I'm sorry.

A. Right. Based -- to put it again into context, based upon what the 911 caller told the dispatcher, with what the officer saw, indicates a medical emergency.

Q. Right. And then it goes on to say, "clearly indicates this man needed emergency help, not a fight with the officers over an arrest," right?

A. Correct.

Q. And based on this hypothetical, you agree with that statement, right?

A. Yes.

Q. And then again, it says in that same paragraph, "bizarre behavior, struggling and resistance can indicate a medical emergency and not a criminal act."

Did I read that correctly?

A. Correct.

Q. And you agree with that statement, right?

A. Yes.

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Q. Do you agree that if someone is exhibiting these behavioral cues, that EMS should be immediately called to the scene?

A. In the ideal world, that would be recommended. Unfortunately, the police department doesn't control EMS.

So EMS may decide we're not going to roll on anything. Because it's really up to the EMS medical director to coordinate that, or the fire department. It's not up to the chief of police. It's not up to anybody, but really the EMS director to determine that.

Q. Can the dispatcher call for EMS?

A. Dispatchers can call for EMS, if there's a protocol for the dispatchers to do that.

But again, that would be whoever the call taker -- you have two elements in any dispatch. You have the call taker, who is going to take down the basic information. Then -- and this hasn't happened. EMS has not -- or I'm sorry, 911 has not put together a call response for excited delirium. That's pretty much a decision made by the 911 folks who know something about it. But it's very rare, very few, very far between. They will just generally have a response to, you know, send a police officer.

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Q. Okay. And I'm not really intending to get into whether the police can force the EMS to come, which I think is kind of what you're talking about, isn't it?

A. Right. They can't force them to do anything.

Q. Right. And aside from that, I mean, you believe that they should be called, though, to the scene immediately, right?

A. The protocol we recommend is they be notified and staged somewhere away from the scene because EMS is not going to come and help the officers.

Q. Right. And I think you even put, "Better yet, EMS should have rolled with the responding officers."

A. Under ideal conditions where the organization gets the cooperation of EMS or fire, the EMS medical director, when all the parties can get together, including mental health and any other stakeholder that may be involved, when that works harmoniously, the idea would be that when the officers are dispatched, where the dispatcher has the behavioral cues, then you would roll EMS. That would be under the ideal conditions.

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Q. Does it work like this: Somebody identifies the behavioral cues, and then makes sure to call EMS, whether it's the dispatcher or the responding officer?
A. Generally, what happens is the dispatchers would go through training; the 911 call taker would go through training. Be told about the behavioral signs.
If he or she hears those behavioral cues during the 911 call, it may be enough for the 911 call taker to tell the dispatcher, look, I think we have the behavioral signs here to roll EMS with the officer. But that's based on training and the protocols of the 911 and the dispatch center. And that's only if the caller, in describing the event, describes one or more of these behavioral signs.
Q. So let's assume if that doesn't happen, then you have the responding officer, right? And then the responding officer could see behavioral cues; is that correct?
A. Correct. They could see behavioral cues.
Q. And then based on those behavioral cues, they could call EMS?
A. They could call EMS. More than likely what they would do first is call for backup.

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Q. And then I'm still on page 2 in the bottom right-hand corner.
A. Right.
Q. It says, "Unless officers can eliminate a reasonable explanation about the person's condition, consider this a medical emergency and get EMS rolling to the scene, if it has not already been dispatched to their location."
A. Correct.
Q. Did I read that correctly? And you agree with that statement?
A. Yes.
Q. Now, next in the article, it looks like you've set out five action steps; is that correct?
A. That's correct.
Q. And what are these action steps for?
A. The action steps are for the capture, control and restraint of the individual. And then if EMS wants to get involved at that point, EMS can get involved.
Q. So one of the later steps involves EMS more, right?
A. It can. Sometimes EMS isn't available. Sometimes EMS protocol, they won't come out. And in those cases, then the officer has to transport.

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The real issue here is don't transport in a police car, transport in an ambulance.
Q. And at the beginning of the five action steps it says, "Many agencies have adopted the following five action steps, which were initially suggested by medical researchers and officials."
Have I read that correctly?
A. Correct.
Q. And is that an accurate statement?
A. Yes.
Q. And I take it because you were writing about these action steps, you would recommend that law enforcement agencies adopt these action steps, correct?
A. Correct.
Q. Now, before you get into the steps here, it looks like you're making a few other recommendations. It says, "develop a plan with other officers and EMS personnel; review the following five-step action plan with them."
A. Correct.
Q. What does that mean?
A. These action steps, to really be implemented, are systemic in nature.
So prior to an agency adopting these, the

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agency head would have to contact the EMS director, maybe the fire personnel, and talk to them and get them on board with the concept.
If EMS and/or fire got on board with the concept, then you would want to bring in mental health, because this may be a mental health issue, and get them on board with it.
Some agencies bring in their district attorney and other investigative agencies to get them involved with it. Because even following those steps doesn't guarantee a good outcome.
So you develop that plan, and that plan has to coordinate so that police has a guideline, EMS has a guideline, fire has a guideline. Mental health is involved, and then maybe your investigators and medical examiners as well.
So it's systemic in nature. It's not where somebody can operate in isolation, and make all these steps work.
Q. And these are things that have to happen before you even get the call?
A. It should happen before you get the call.
Q. Right. And then I think in the plan here, it says, "After reasonably assessing the scene, and if time permits you to do so safely, develop a plan

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with other officers and EMS personnel."
Is that something you're talking about doing there at the scene, right?
A. Generally, if you have all these action steps in place, you've already included everybody in your training. And all you're going to do is just say, okay, we're going to capture, control and restrain EMS, and then you come in and do your intervention.
So you sort of look at it that way.
Most of the time in reality, EMS, it's not going to happen at the front end. EMS will roll up after the person is restrained.
Then you can say to EMS, okay, he's restrained, here's what we saw. They're taking vitals, and then they will decide from there.
Police are out of the picture at that point for the most part.
Q. Are you kind of saying when you get to the same kind of just -- if you already have this plan in place, just remind all the other officers, hey, we're going to go with the five-step plan. Is that where you're coming from?
A. Pretty much. If time permits.
Q. Then it says, "Attempt to de-escalate the

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situation through verbal skills," and then in parentheses, "notice I did not say commands."
Did I read that correctly?
A. Correct.
Q. Did I read that correctly?
A. Correct.
Q. And you agree with that statement?
A. Yes. In this scenario, yes.
Q. Why did you put the part in the parentheses that says, "notice I did not say commands"?
A. Usually commands are given very loudly. And the hypothetical suspect in this case, that may tend to have not a calming effect on the person. They may not hear it.
So you try -- usually it's sort of a continuum, if you will, where you start with, you know, requesting, and then you ultimately get to the command phase potentially. But you would start with more conversational-type directions, would be a good term.
Q. Can you give me an example of how that's done.
A. Yeah, Appleton, Wisconsin had a great video, captured the whole thing on video actually. The guy's name was Tim. And the officer arrived.

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And Tim was later found to be having an allergic reaction to mushrooms. You know, hallucinogenic mushrooms.
And Tim was yelling and screaming, and then he would say, "I'm going to get on the floor."
And the officer in a very calm voice said, "Tim, why don't you get on the floor." And then Tim got onto the floor.
And the officer said, "We need to take you to the hospital. You're having a reaction to something."
But then as Tim's behavior escalated, the officer got a little louder, and commanded him to stop. And then at one point, the officer said, "Get him out of here."
EMS came, took him out.
So in a sense, when you're doing this, it's called matching. If the person is yelling real loud, then you try to bring your voice down, and hopefully he'll match, and it won't turn into a screaming match.
But it's all directed by the suspect or the person who is having the medical problem. That's usually who drives the machine.
Q. And then step one is, "Quickly and safely

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capture the person."
A. Correct.
Q. Is that correct? And you recommend doing that with a taser; is that right?
A. Taser is the recommended capture device at a distance. Carotid restraint is the recommended technique if you're in close.
But again, not every agency carries a taser. Not every agency teaches the carotid restraint. Those are the two recommended. If they don't carry it, they can't use it, so they will have to do something else.
Q. What is the carotid restraint?
A. It's just -- we refer to it as a blood choke. It's just applying the forearm along the carotid artery side of the neck and applying pressure, rendering the person unconscious temporarily and then doing what you need to do.
Q. And then step two is, "Quickly and safely control the person," correct?
A. Correct.
Q. And you say that that should be done by one or more officers safely grabbing both arms or all of the appendages; is that correct?
A. Correct.

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Q. Is that correct?
A. Yes.
Q. Sorry, I'm not trying to talk over you.
A. That's all right.
Q. By appendages, did you mean arms and legs?
A. Generally arms and legs. And grabbing him sometimes doesn't work. Sometimes you have to lay across them.
Basically, trying to control them and gain access to them. You can't handcuff the wrist if you can't get the arm, so you have got to get the wrist.
Q. Then step three is, "Quickly and safely restrain the person."
A. Correct.
Q. And you say that should be done "with plastic or metallic restraints, nylon restraints, leather restraints, restraint combinations, and so forth."
A. Right.
Q. So it's pretty wide open on how that's done?
A. Well, it's fairly wide open because different agencies carry different types of restraint equipment.
If you have a standard set of handcuffs,

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and the guy is real big, you might need two or three sets of handcuffs. If you have plastic ties, you might use plastic ties. It just depends. It depends on the size of the person, the strength of the person, where you're located, how many people you've arrested at that point. You may be short on equipment.
Q. And then it says it is not recommended that the -- "It is recommended that the person not be left in the prone position for an unreasonable time, but rather rolled onto the side or sitting upright," correct?
A. Correct.
Q. And then step four is, "sedate the individual." Correct?
A. Correct. That's an EMS decision. That's not a law enforcement decision.
Q. Right, and that's what I was going to ask you. So you say that should be done by the paramedics on the scene, right?
A. Correct. It cannot be done by EMTs because they're not authorized. It has to be done by only paramedics, and those paramedics will get all their guidance from the EMS director.
And even though they may have sedation

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drugs in their rig or in their kit, the EMS director may prohibit it, and say bring him to the hospital.
So that step is totally out of law enforcement's control.
Q. And then step five is, "Immediately transport the person to the hospital," correct?
A. Correct.
Q. So then the next section after the five-step plan, you recommend that law enforcement agencies develop a response team which can be immediately dispatched to the scene of an individual who demonstrates one or more behavioral cues, correct?
A. Correct.
Q. And you agree with that recommendation?
A. I agree with it, provided the agency is large enough to have it. I mean, if you have a two-person police department, you're not going to have a response team.
But again, this response team would include EMS. It would include all the people we talked about earlier.
So again, it's that systemic response, including possibly DA investigators, or highway patrol investigators, state police, whatever.

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Q. And then you say, "This response team should be trained in how to recognize behavioral signs, restraint techniques, report writing, and investigation techniques."
Did I read that right?
A. That's correct.
Q. And you agree with that?
A. Yes.
Q. Then if you look to the summary, you say that, "There are many agencies throughout the United States which have adopted the five-step action plan as outlined above, or with slight modifications."
Did I read that correctly?
A. Yes.
Q. And is that an accurate statement?
A. Yes.
Q. Then it looks like you go on to talk about the Jacksonville, Florida Sheriff's Department; is that right?
A. Yes.
Q. And you state that they, "have several Identification, Prevention, Management and Investigation of Sudden and In-Custody Death qualified instructors."

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A. Correct.
Q. Is that correct? And that's an accurate statement?
A. Yes.
Q. And then you say, "It has developed a systematic approach to these situations."
Is that accurate?
A. Yes.
Q. Then you go on to say how the Jacksonville Sheriff's Department Administration made it a point to first train its dispatchers "so they would know what to look and listen for during a 911 call, and then dispatch the appropriate resources."
Did I read that correctly?
A. That's correct.
Q. And is that an accurate statement?
A. Yes.
Q. And then if we go to Final Thoughts. You state, "If one or more behavioral cue is identified, dispatch and/or responding officers should immediately request EMS to be sent directly to the scene, along with additional officers and a supervisor."
Did I read that right?
A. Correct.

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Q. And you agree with that statement?
A. Yes.
Q. And then you say, "The restrained individual should immediately be taken to the hospital. Taking the person to the police station or to jail will only waste precious, potentially lifesaving time, so go directly to the hospital."
Did I read that correctly?
A. Yes.
Q. And do you agree with that statement?
A. Yes.
Q. Then you say, "For those officers who are out in the county by themselves, or the local EMS service is temporarily out of service, sit the person upright in the backseat of the police car, seat belt and shoulder harness him (or her) and then proceed directly to the hospital."
Did I read that correctly?
A. Correct.
Q. And do you agree with that statement?
A. Yes.
Q. And then finally, you say, "It is strongly recommended that a second officer sit in the backseat with the individual so he can be continuously monitored."

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A. That's correct.
Q. Did I read that correctly?
A. Yes.
Q. And you agree with that statement?
A. If there's room, yes.
Q. And just to synthesize that, if I understand that, if EMS isn't available right away, the police officer should take the person straight to the hospital, right?
A. Correct. Instead of going to jail, you take them to the hospital. The real point here is take them to the hospital, don't take them to jail.
Q. You don't want to waste any time, right?
A. Well, time is an issue. Because if you take them to the jail, and the jail refuses, then now you've wasted that transport time, now you've got to go to the hospital.
Q. Better just to take them straight to the hospital?
A. Right.
Q. I would now like to turn to another article that it looks like you wrote for Police and Security News. This is one that I provided to you. It's called, Excited Delirium, What Every Chief Needs to Know.

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A. Okay.
MR. HENSON: Hold on just a second, Kevin. We got it.
BY MR. CARNIE:
Q. Can you identify that article for me?
A. Again, this is a resized reproduction of the Police and Security News article that appeared in the September/October 2007, Police and Security News magazine.
Q. Why did you write that article?
A. Basically, we found that a lot of chiefs and administrators around the country just didn't know about excited delirium. So we thought this is something that would go to the chief. And we were hoping that if a chief saw this article, he or she might look at it and is say, you know, this might be something we need to look at.
So we were just trying to educate chiefs a little bit, and administrators.
Q. And in particular, it seems to deal with how they interact with the media, right?
A. Part of it is the media response. Cursory analysis of administrators, not only in the police department, but public information officers and whomever meet the media. They didn't know anything

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THE COURT REPORTER: Thank you.
THE VIDEOGRAPHER: This concludes the videotaped deposition of Dr. John G. Peters, Jr. consisting of five tapes, on Thursday, August 29th, 2013.
The original tapes of this testimony will remain in the custody of Las Vegas Legal Video.
The time is approximately 2:32 p.m. We're now off the record.

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(The videotaped deposition was concluded at 2:32 p.m.)

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CERTIFICATE OF DEPONENT

PAGE	LINE	CHANGE	REASON

* * * * *

I, JOHN G. PETERS, JR., Ph.D., deponent herein, do hereby certify and declare under penalty of perjury the within and foregoing transcription to be my deposition in said action; that I have read, corrected and do hereby affix my signature to said deposition.

JOHN G. PETERS, JR., Ph.D.
Deponent

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CERTIFICATE OF REPORTER

I, the undersigned, a Certified Shorthand Reporter of the State of Nevada, do hereby certify:
That the foregoing proceedings were taken before me at the time and place herein set forth; that any witnesses in the foregoing proceedings, prior to testifying, were duly sworn; that a record of the proceedings was made by me using machine shorthand which was thereafter transcribed under my direction; that the foregoing transcript is a true record of the testimony given to the best of my ability.
Further, that before completion of the proceedings, review of the transcript [X] was [ ] was not requested pursuant to NRCP 30(e).
I further certify I am neither financially interested in the action, nor a relative or employee of any attorney or party to this action.
IN WITNESS WHEREOF, I have this date subscribed my name.

Dated: September 3, 2013

GALE SALERNO, RMR, CCR No. 542